Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 19 January 2022

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Title:	**Learning from deaths report – Quarter Q2 2021-22**

Status:	**For Information**
History:	**This is a quarterly paper to the Trust Board**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises the key learning identified in the mortality reviews completed for quarter 2 of 2021/22 and performance for the latest available Dr Foster Intelligence data, providing assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.
2. Investigating mortality, and reporting data, enable identification of further ways to improve patient outcomes and safety.
3. During quarter 2 of 2021/22 there were 629 inpatient deaths reported at OUH. 96% (604) cases were reviewed within 8 weeks. Of these reviews, there were 407 (65%) comprehensive Level 2 reviews and 7 (1%) structured mortality reviews completed.
4. All COVID-19 related deaths were subjected to a Level 1 screening mortality review. There have been no COVID-19 related deaths judged more likely than not to have been due to problems in the care provided.
5. An overarching SIRI investigation has concluded for all nosocomial COVID-19 probable or definite deaths resulting from the second wave (Autumn 2020 – end June 2021). This report has been presented at the December Mortality Review Group meeting. A summary of the findings is discussed in this report.
6. No deaths occurring during Quarter 2 were deemed to be ‘avoidable’.
7. There were no alerts via Dr Foster that required investigation in this quarter.
8. The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2020 to June 2021 is 0.92 and remains rated ‘as expected.’ The Hospital Standardised Mortality Ratio (HSMR) is 86.3 for the data period July 2020 to June 2021 and remains rated positively as ‘lower than expected’.

Recommendations

9. The Public Trust Board is asked to receive this paper for information and discuss the learning identified from mortality reviews.

Contents

Learning from deaths report – Quarter Q2 2021-22

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for quarter 2 of 2021/22.

1.2. This report provides a quarterly overview of Trust-level mortality data for the period of quarter 2: July 2021 – September 2021, and performance for the latest available Dr Foster Intelligence data, providing assurance that any highlighted concerns are investigated thoroughly, and appropriate action is taken.

2. Background and Policy

2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework:

- Preventing people from dying prematurely.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.2. OUH uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a ‘warning’ of potential problems and help identify areas for investigation.

2.3. The Trust Mortality Review policy requires that all inpatient deaths be reviewed within 8 weeks of the death occurring. All deaths have a Level 1 review.

2.4. The aim is for all Level 1 mortality reviews to be completed by a Consultant independent of the case however with the current capacity constraints this is not possible in all cases. To mitigate this 25% of Level 1 reviews are selected at random for a Level 2 review and all (100%) of deaths undergo scrutiny from the Medical Examiner.

2.5. If there are any concerns identified, a comprehensive Level 2 review is completed involving one or more consultants not directly involved in the patient's care. A structured review, completed by a trained reviewer who was not directly involved in the patient's care, is required if the case complies with one of the mandated criteria.

2.6. Each Division maintains a log of actions from mortality reviews and monitors progress by their clinical units. The clinical units are responsible for disseminating learning and implementing the actions identified.

2.7. The Divisions provide updates on actions in the monthly quality reports to the Clinical Governance Committee (CGC). The Divisions also provide updates to the Mortality Review Group (MRG) on the previous quarter's actions as part of the next quarter's mortality report. The Mortality Review Group reports to the Clinical Improvement Committee.

3. Mortality reviews during quarter 2 of 2021/22

Table 1: Number of mortality reviews completed during Quarter 2 of 2021/22:

Total deaths	Total reviews (L1, L2 or SJR)	Deaths not reviewed within 8 weeks
629	604 (96%)	25 (4%)

3.1 During quarter 2 of 2021/22 there were 629 inpatient deaths reported at OUH. Compliance with mortality reviews as per the agreed policy is presented in Table 1. There were 604 (96%) cases reviewed within 8 weeks. Of these reviews, there were 407 (65%) comprehensive Level 2 reviews and 7 (1%) structured mortality reviews. The 25 remaining cases have been escalated and discussion at local M&M meetings is planned and will be followed up at MRG.

3.2 Trust wide, there were 7 structured reviews completed during Quarter 2 of 2021/22. The reasons for completing the structured review include learning disability, concerns raised by staff of families and concerns raised during the Medical Examiner scrutiny. Learning and recommendations from the completed structured reviews are included in this report.

3.3 During quarter 2 of 2021/22, there were no patient deaths at the OUH judged more likely than not to have been due to problems in the care provided.

4. The Medical Examiner system

4.1. The purpose of the Medical Examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths, ensure appropriate direction of deaths to a Coroner, provide a better service for the bereaved, provide an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification and improve the quality of mortality data.

4.2. The Medical Examiners (MEs) have monthly meetings to review progress and discuss cases. The feedback received by the MEs from bereaved families as to how they are informed of the deaths of their relatives has led to discussion and review of processes in wards.

4.3. The feedback received by the MEs has been shared promptly with the ward teams. This has raised the profile of the ME system within the Trust and clinical teams are recognising and appreciating the ME role as part of the existing Bereavement system.

4.4. The opportunity for families to discuss the care their relative received with an ME has been positively received. To quote one relative, the ME communication was an 'excellent adjunct' to the care provided.

4.5. In line with the Department of Health and Social Care directive; the Lead Medical Examiner is reviewing the deaths of any members of staff involving COVID-19.

4.6. Planning is now underway to confirm a process for the scrutiny of deaths by the ME in the community.

4.7. In the Quarter no issues were raised by the ME that had not already been identified by the Trust.

5. Child death overview process

5.1. The statutory requirement to establish a panel that would review every child death in their local area has been in place since 2006 (section 14 of the Children Act 2004). These regulations were further developed in Working Together to Safeguard Children (2018).

5.2. The specific functions as laid down in the statutory guidance require the panel to review the available information of deaths of all children up to the age of 18 years. This includes the deaths of infants less than 28 days, including those

born before viability, but not those who are stillborn or are terminated pregnancies within the law.

5.3. The Oxfordshire CDOP is committed to the process of systematically reviewing all children's deaths, ensuring the child death review process is grounded in respect for the rights of children and their families, and focused where possible on preventing future child deaths.

5.4. The administration of the Oxfordshire CDOP is hosted by Oxfordshire Clinical Commissioning Group (OCCG) and is chaired by the Director of Quality and Lead Nurse from the OCCG. The Designated Doctor for Child Death is a Consultant Paediatrician at the Oxford University Hospitals NHS Foundation Trust and is commissioned by the OCCG to undertake this role.

6. Learning and actions from mortality reviews quarter 2 of 2021/22

Investigation into Nosocomial COVID-19 deaths

6.1. An investigation into all 58 probable and definite nosocomial COVID-19 transmissions resulting in death or serious harm has been completed. Each case was individually reviewed at regular meetings Chaired by the Director of Patient Safety & Effectiveness together with the Infection Prevention & Control team, Patient Safety Team, Divisional Governance colleagues and Health & Safety. The most deaths were found in male white British patients presenting with comorbidities and in the age group 80-89. Interventions identified were communicated alongside the investigation and disseminated at regular COVID-19 Clinical Forums which then cascaded information via regular staff Safety Huddles to ensure rapid dissemination.

The following issues and contributing factors were identified:

Outbreaks

- Once a nosocomial outbreak was identified patients were cohorted to minimise further spread as per UK Health Security Agency guidance

Established estates issues

- Given the age of the buildings, much of the estate relies on natural ventilation to supplement poor mechanical ventilation and engineering solutions are limited.
- Given the small size of staff break rooms it was challenging to ensure full social distancing. It was recommended that the use of the break rooms be staggered where possible given the number of staff requiring access

- The size of wards and the number of staff required also posed a challenge to enacting social distancing
- Lack of side rooms for isolating infected patients
- Shared facilities

Patient movement around sites

- Patients may be required to move around the site dependant on clinical requirements, potentially exposing an increased number of other patients should they be subsequently identified as COVID-positive.

The introduction of day 3 swabs

- This practice was introduced on 16 December and included in Trust communications on 24 December
- 41 of the 210 Probable and Definite nosocomial infections identified occurred before the implementation of day 3 swabbing, therefore we may have been unaware of cases who were incubating COVID-19 on admission.

PPE

- Patients were made aware of the need to wear facemasks if leaving their bedspace, however compliance was dependant on cognitive ability, clinical exemption from mask use, and patient choice.

Root Cause:

The root cause was identified as the combination of challenging circumstances required to contain a highly infectious respiratory pathogen during a pandemic within a complex healthcare setting. Contributary factors were limited isolation, patient and staff facilities, a reliance on natural ventilation in many ward areas, and the continued requirement to deliver non-COVID-19 healthcare across emergency and elective pathways during a pandemic.

Learning and actions taken

- COVID-19 Safety Audit continue to be completed at least once a month by all inpatient areas. This audit includes Personal Protective Equipment (PPE), patient screening and adherence with social distancing and staff testing. The audit results are reviewed by Ward Managers and the findings and areas for improvement are shared with staff. The audit results are included in the monthly Divisional Quality Reports submitted to the Clinical Governance Committee (CGC).
- Emphasis on COVID-19 swabs for inpatients being done on the day of admission, day 3 and then weekly. Safety messages to reiterate has been circulated. High incidence of staff leave around Christmas may have impacted on the successful implementation.

- Ventilation risk assessments have been completed for all areas with risks added to the Divisional Risk Registers and ventilation programmes adhered to.
- Safety Huddles have been held to inform ward staff in 'real time' of changes that may affect their clinical practice in relation to COVID-19.

6.2. The report has been presented at Divisional governance meetings and cascaded accordingly amongst Directorates and Services.

Learning from other SIRI and mortality cases

6.3. Reminders have been provided to clinical teams regarding the importance of communication and updating of families when a patient's clinical status changes.

6.4. Ensure VTE assessments are completed and reviewed according to trust guidelines.

6.5. Challenge of managing complex patients across multiple Teams has been highlighted, particularly when the managing team is relying on specialist advice that is obtained from a variety of people. The importance of the effective use of electronic systems was also highlighted in this case.

6.6. In one case the Power of Attorney was not identified during admission and incorrect family member was informed of the diagnosis and subsequent death.

6.7. Important messages such as DNACPR status cannot be added to the patient banner in the Medisoft® system (used by the Ophthalmology Directorate). This has been highlighted to the teams involved and a solution is currently in progress.

6.8. SUWON Division highlighted the importance of ensuring staff remain up to date on trust guidance and policies.

6.9. The importance of team debriefs following patient arrests in complex cases is being actioned

7. Patient safety incidents with an impact of death and subsequent SIRI investigations declared during Q2

7.1. Seven out of eleven incidents with an impact of death were the subject of a Root Cause Analysis, five were at Trust Level Serious Incident Requiring Investigation (SIRI).

7.2. These concerned:

7.2.1. A patient with indications of endometrial cancer had laparoscopic surgery. They were discharged home where they later deteriorated and died.

7.2.2. A patient fell from the operating table during a coronary angiogram procedure. They sustained a head injury and later died.

7.2.3. A baby was delivered in the hospital car park following a cord prolapse. The baby went to the neonatal unit where they later died. This incident is being investigated by the Healthcare Safety Investigation Branch.

7.2.4. A patient unexpectedly suffered a cardiac arrest in the emergency department and subsequently died.

7.2.5. A patient who underwent an oesophagus-gastro-duodenoscopy had an oesophageal perforation and later died.

7.3. An additional investigation into all probable and definite Oxford University Hospitals NHS Foundation Trust nosocomial COVID-19 transmissions resulting in death or serious harm from the third wave of COVID-19 was declared.

7.4. These investigations are currently in progress and any relevant learning will be included in future learning from deaths reports.

8. Vulnerable Adults Meeting (VAM) feedback following reviews completed in the region

8.1. It has been noted by clinical teams and the VAM that some Vulnerable adults may not tolerate some complex investigations for example MRI scans and these investigations then do not take place. The VAM highlighted that any *reasonable adjustments* that will enable the person to tolerate the procedure should also be considered and that the individuals capacity assessment and reason for decision should be documented.

8.2. Providers must ensure that the reason for a DNACPR does not include Learning Disability. In Quarter 2, one out of a total of 12 Learning Disability patients (8%) had LD listed last on the reason for DNACPR. This will be taken forward as a Quality Improvement project to ensure this position improves.

8.3. The ongoing support provided to patients by their usual carers on wards is highly valued, but it is important to ensure staff have discussed roles and what they are comfortable to do. Carers had been involved in last offices and had then felt this had not been appropriate.

8.4. The above recommendations will be discussed within the Divisions and resulting actions will be monitored by the central governance function.

9. LeDeR Annual Report summary 2020/21

9.1. During this quarter the annual learning disability death review (LeDeR) report was published.

9.2. This is the Fourth Annual Report collating learning from the mortality reviews of those living with a learning disability using the LeDeR framework. The review process is a strongly supported partnership activity in Oxfordshire, with membership from a wide range of organisations. This report presents the findings from the 61 case reviews undertaken in 2020-2021.

9.3. The panel has supported a new rapid review process that critically reviews and seeks to identify any local issues and learning resulting in improved timeliness of review completion. The rapid reviews undertaken led to changed visiting arrangements for those requiring additional support, changes to communications with care providers and families and the development of COVID-19 passports.

9.4. 41 notifications were received, and 61 case reviews completed. 97% of reviews notified to Oxfordshire in 2020-21 were completed within the 6-month target set by NHS England.

9.5. The average number of notifications of deaths per month in 2019-20 was less than 4 and this has remained consistent in 2020-21. Locally the data has been cross referenced to ensure no individual was missed from the review process. Whilst there has been no specific learning identified to account for this the steering group acknowledged that there are a very high number of small, supported living settings, more family like units, which may have been factors.

9.6. Learning from the LeDeR process has been a regular report component of the Learning Disability and Autism system wide group, that was set up as part of the COVID-19 reporting structures and will be sustained to create a forum for ensuring providers and commissioners regularly review quality and effectiveness through a range of perspectives.

9.7. Learning has been shared in webinars, through a series called “Wednesday at One”. This series consisted of 10 sessions, each with a key focus that explored healthy lifestyle issues, advanced/ proactive care planning and health care plans, understanding the individuals’ experience and supporting health needs such as epilepsy.

9.8. Key areas identified as a focus for further improvement:

9.9. Annual Health Checks (AHCs) and Health Action Plans (HAPs) / Education and Health Care Plans (EHCPs) need to be more closely aligned and linked so they inform each other, both being valued by all.

9.10. Transition from child to adult services needs to start with earlier discussions across teams and service, including primary care. This needs to include hearing the voice of the individual, their views, and choices more consistently, whilst not excluding families.

9.11. Anticipatory care plans and preparing for lifestyle changes needs to be more proactively supported across the system, including end of life choices, best interest decisions, advocacy, and family roles.

10. Further analysis of structured mortality reviews completed during the quarter:

Background:

10.1. Each quarter this report will focus on a deeper analysis into a specific area of clinical outcomes.

10.1.1. Quarters 1 and 3 will focus on a deeper analysis of mortality indicators for a specific diagnosis group.

10.1.2. Quarters 2 and 4 will focus on a deeper analysis of structured reviews completed and presented to the mortality review group.

10.2. This quarter the report will focus on structured reviews completed during quarter 2 and associated learning.

10.3. Structured mortality review blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

10.4. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems, or difficulty in the care process.

10.5. Structured review is mandated in the following circumstances:

10.5.1. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.

10.5.2. All in-patient, out-patient, and community patient deaths of those with learning disabilities.

10.5.3. All deaths in a service specialty, particular diagnosis, or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).

10.5.4. All deaths in areas where people are not expected to die, for example in relevant elective procedures.

10.5.5. Deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.

10.5.6. A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall.

10.6. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care (table 2).

Table 2: Analysis of Structured Reviews

	Surgical?	Admission phase	Ongoing care	Procedural care	Perioperative care	End of life care	Overall assessment
Patient 1	Yes	3	4	4	4	4	4
Patient 2	Yes	3	N/A	4	3	3	3
Patient 3	No	3	3	N/A	N/A	4	3
Patient 4	No	5	4	N/A	N/A	4	4
Patient 5	Yes	4	3	3	3	3	3
Patient 6	No	5	4	N/A	N/A	4	4
Patient 7	No	3	4	N/A	N/A	4	3
Total		25/35	22/30	11/15	10/15	26/35	24/35

Phase of care scores are recorded as - 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent care

Analysis:

Discussion:

10.7. The seven patients were all discussed at the mortality review group meetings 15 July, 19 August and 16 September.

10.8. Of the completed reviews, all learning disability cases, cases involving a serious incident investigation and any case where care quality concerns are identified must be presented to the mortality review group.

10.9. Four of the above cases involved patients with a learning disability and three cases were highlighted due to staff concerns. None of these case reviews demonstrated preventable deaths.

10.10. No death was deemed to be avoidable.

10.11. Previous audits of completed structured reviews gave recommendations for patient care to improve the end-of-life phase of care scoring.

This quarterly review has highlighted end-of-life care as the highest scoring phase of care from the completed mortality reviews.

A focus on end-of-life care was also included in the Quality Account for 2020/21.

10.12. Other actions to improve end of life care include:

10.12.1. The hospital palliative care team adopted national guidance on the management of symptoms due to COVID-19 and developed some additional local guidance. Information was made available on the intranet in addition to providing teaching for staff as requested.

10.12.2. Palliative care unit staff (Sobell House Hospice) moved site to meet the clinical need over the year attending the hospital, hospice and community as needed.

10.12.3. During the first wave three members of OUH staff were redeployed to the hospital palliative care team and medical staff from Katharine House Hospice and Helen and Douglas House joined the hospital team to support the care of patients dying in OUH enabling seven-day consultant presence in the John Radcliffe Hospital for two months.

10.12.4. Further guidance on scoring for the end-of-life phase of care section has been included in the structured mortality review training.

10.12.5. A link to specific guidance to review end-of -life care has been included on the structured mortality review form.

Issues identified and learning:

10.13. A challenge was raised relating to one case and if a score of 3 needed to be reviewed considering the fact the patient was deemed to be high risk and the surgery was performed at a weekend. This was reviewed and given the circumstances of operational pressures arising from the pandemic it was felt that this patient had received acceptable care.

10.14. One case was escalated for further investigation as a Trust level SIRI. This report has now been completed and highlighted the need for escalation of care within primary care following procedures. This has been highlighted to the CCG.

10.15. In one case, the overall assessment of care was updated to a score of 5 – excellent care.

10.16. Training to complete reviews is provided internally monthly, the current number of trained reviewers by division can be seen in table 3.

Table 3: Structure Review Training by profession

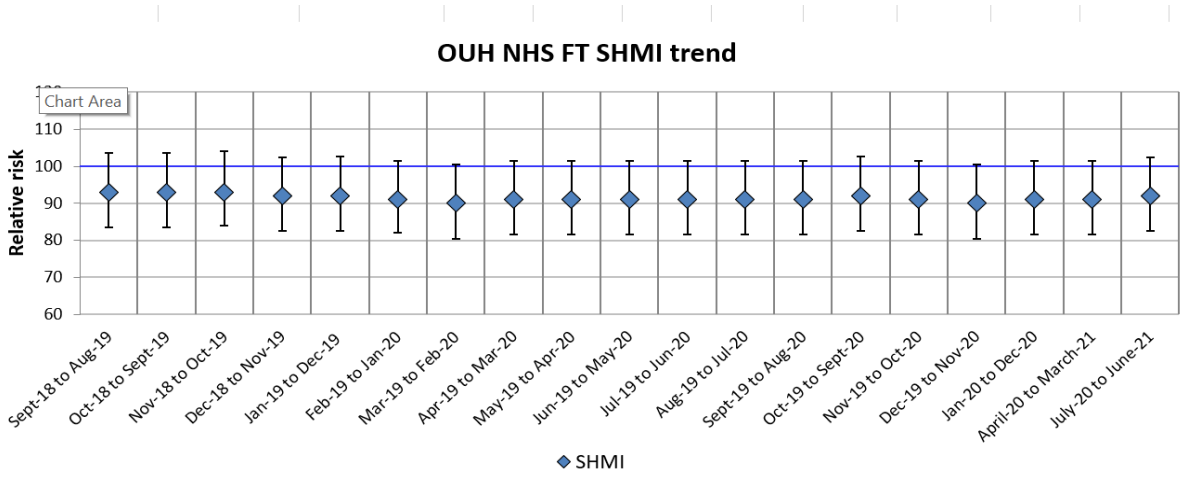
Division	Trained Lead Reviewers	Consultant	Nurses	Other
MRC	63	48	11	4

Division	Trained Lead Reviewers	Consultant	Nurses	Other
CSS	19	12	6	1
NOTSSCaN	30	19	10	1
SuWOn	55	31	18	6
Corporate	10	1	1	8
Trust total	**169**	**106**	**43**	**20**

11. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)

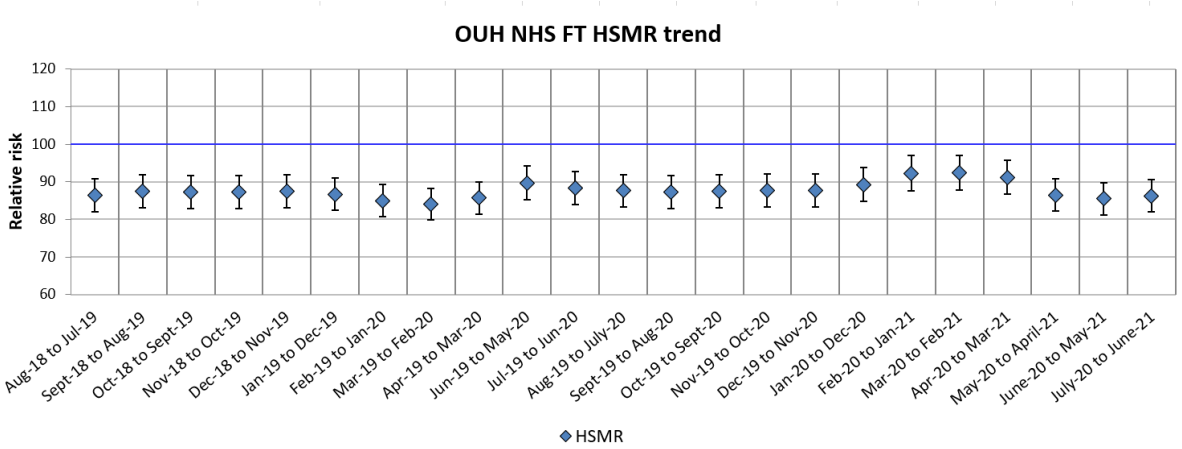
11.1. There have been no mortality outliers reported for OUH from the CQC or the Dr Foster Unit at Imperial College during quarter 2.

11.2. The SHMI for the data period July 2020 to June 2021 is 0.92. This is rated 'as expected.' Chart 1 depicts the SHMI trend. The SHMI has remained rated 'as expected.



11.3. The HSMR is 86.3 for the data period July 2020 to June 2021. Chart 2 depicts the HSMR trend. The HSMR has remained rated 'lower than expected.'

Chart 2: HSMR trend



Key differences between the SHMI and HSMR

11.4. The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR produced by Dr Foster Intelligence.

11.5. Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

11.6. While both mortality indicators use slightly different methodology to arrive at the indicator value; both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR) to ascertain whether a trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

Table 4: Key differences between the SHMI and HSMR

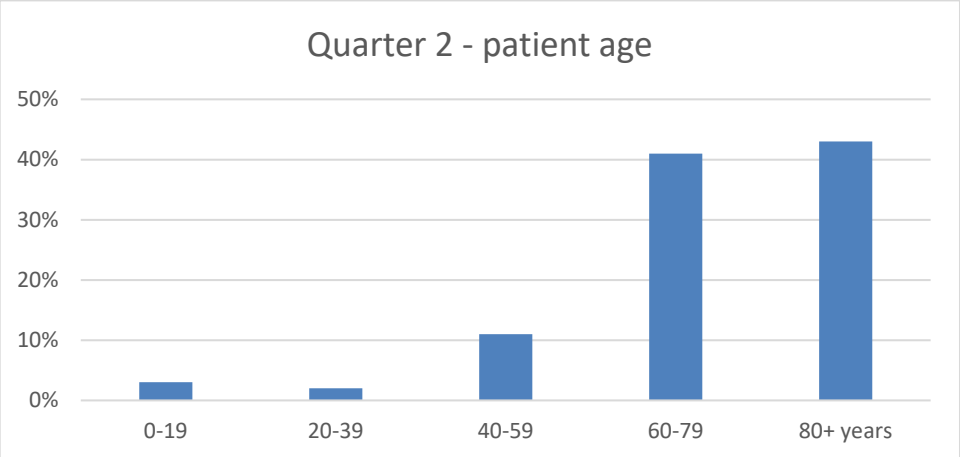
Indicator	**Summary Hospital-level Mortality Indicator (SHMI)**	**Hospital Standardised Mortality Ratio (HSMR)**
Published by	NHS Digital	Dr Foster Intelligence
Publication frequency	Monthly	Monthly
Data period to calculate indicator value	Rolling 12-month period for each release, approximately five months in arrears.	Provider-selected period, up to three months in arrears
Coverage	Deaths occurring in hospital or within 30 days of discharge. All diagnosis groups excluding stillbirths. Day cases and regular attenders are excluded.	In-hospital deaths for 56 selected diagnosis groups that accounts for 80% of in-hospital mortality. Regular attenders are excluded.

Indicator	Summary Hospital-level Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
Assignment of deaths	Deaths that happen post transfer count against the transfer hospital (acute non-specialist trusts only).	Includes deaths that occur post transfer to another hospital (superspell effect).
Palliative Care	Not adjusted for in the model.	Adjusted for in the model.
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birth weight (for individuals aged <1 year in perinatal diagnosis group).	12 factors: admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Charlson comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, palliative care, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.

12. Analysis of mortality during Quarter 2

12.1. 41% of deaths occurred in patients aged 60 to 79 years and 43% in patients over 80 years of age (Chart 3).

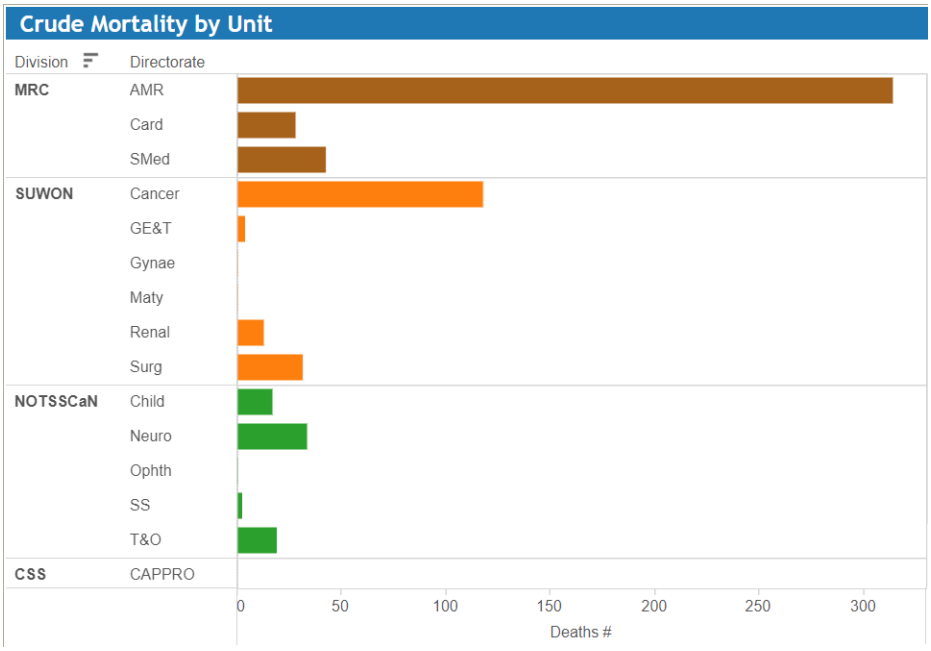
Chart 3: Mortality – patient age



12.2. There was at least one co-morbidity in all cases. Chronic kidney disease, dementia and ischaemic heart disease were the most common co-morbidities found among non-COVID-19 deaths.

12.3. The highest number of deaths were admitted to the Acute Medicine and Rehabilitation (AMR) Directorate under the MRC Division (Chart 4).

Chart 4: Deaths by Directorate



12.4. Of the 326 deaths for the period of quarter 2 occurring under the AMR directorate, 235 (72%) of deaths occurred under the speciality of acute general medicine.

12.5. Ethnicity data can be seen below in table 5.

Table 5: Death by ethnic background:

Ethnicity	Total
White British	464
Not Stated	109
Not Known	17
Any Other White Background	15
African	9
Any Other Ethnic Group	8
White Irish	6
Any Other Asian Background	4
White and Black Caribbean	2
Pakistani	2

Ethnicity	Total
Indian	2
Caribbean	1

12.6. VLAD charts are statistical process control charts which provide a visual comparison between an expected outcome and its associated observed outcome. VLAD charts enable the depiction of trends in outcomes over time and the detection of variations within the reporting period for a particular diagnosis group. These charts facilitate the monitoring of mortality outcomes within the Trust compared to the national baseline and provides trigger alerting when a run of individual patient outcomes trends outside the expected range.

12.6.1. NHS Digital publishes VLAD charts for 10 SHMI diagnosis groups selected because they have high levels of patient activity and risk models that are considered to have sufficiently explained the expected variation in outcomes due to the case-mix adjustment.

12.6.2. A downward trend indicates a run of more deaths than expected. An upward trend indicates a run of fewer deaths than expected. The control limits (which are shown with a dotted line) enable alerts to be generated when a run of individual patient outcomes trends outside of expected levels. The VLAD charts alerts for the period July 2020 to June 2021 are listed below; these will all have been notified to the relevant Divisions, reviewed and any learning shared at MRG:

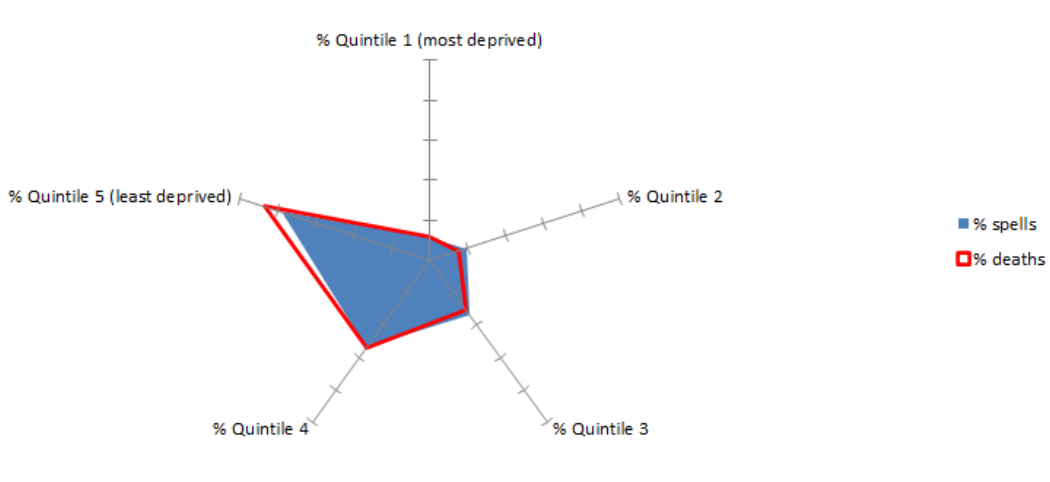
VLAD Charts	Discharge Date	Control limit crossed
Septicaemia (except in labour)	20/07/20	Upper
Fluid and electrolytes	06/11/20	Upper
Pneumonia	13/07/20	Upper
	06/08/20	Upper

12.7. NHS Digital reference the same spell level information which was used to calculate the SHMI to report the percentage rates of deaths under each social deprivation quintile.

12.8. Deprivation quintiles are calculated using the Index of Multiple Deprivation (IMD) Overall Rank field in the Hospital Episodes Statistics (HES) dataset which is based on a weighted combination of factors such as income; employment; health deprivation and disability; education, skills, and training; barriers to housing and services; crime and living environment.

12.9. Chart 5 displays the percentage breakdown of spells and deaths by deprivation quintile. There remains a higher percentage of deaths in the least deprived group (quintile 5) relative to the percentage of spells attributed to those quintiles; conversely there were fewer deaths observed in quintile 2 relative to the number of spells linked to that group.

Chart 5: % SHMI spells and deaths by deprivation quintile

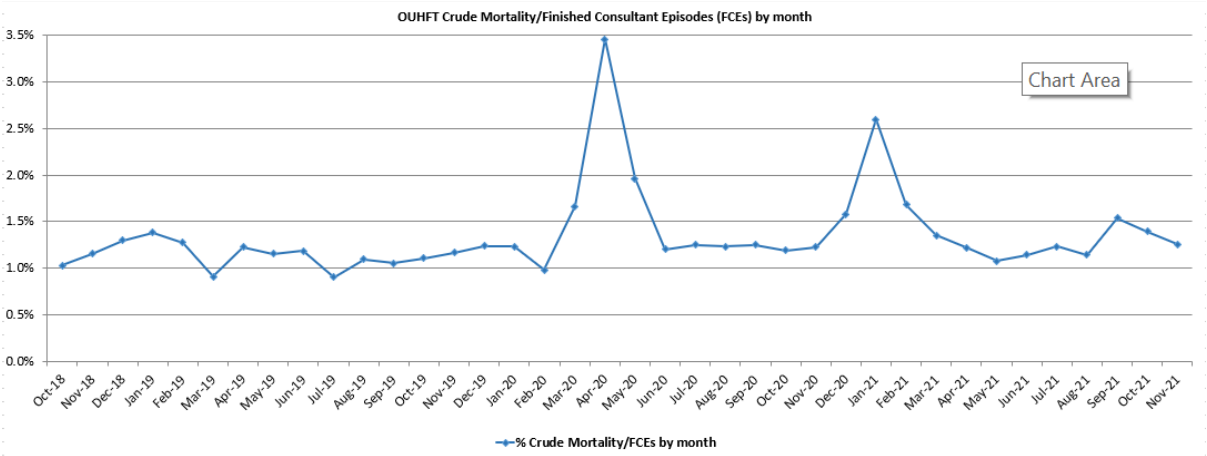


13. Crude Mortality

13.1. Crude mortality gives a contemporaneous, but not risk-adjusted, view of mortality across OUH.

13.2. There was a sharp increase in the mortality rate in April 2020 due to the increased number of deaths and decrease in activity related to the COVID-19 pandemic. There was a rise in the mortality rate in January 2021 resulting from the increase in the number of deaths related to the further wave of the COVID-19 pandemic. Chart 6 depicts the crude mortality rate by Finished Consultant Episodes (FCEs).

Chart 6: Crude mortality rate by Finished Consultant Episodes (FCEs)



13.3. During quarter 2 of 2021/22:

13.3.1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's, and Neonatology Division reported that 74 patients died from a total of 13,356 discharges.

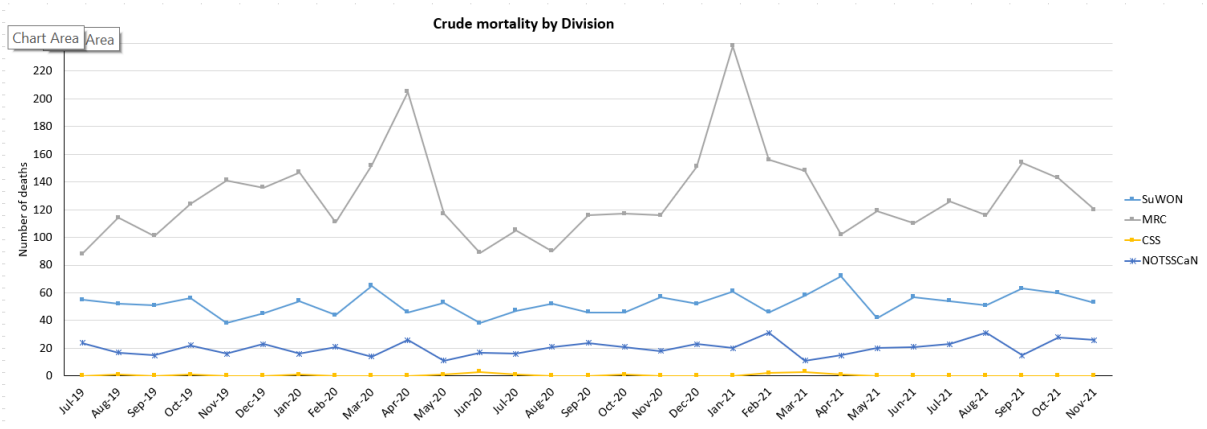
13.3.2. Medical Rehabilitation and Cardiac Division reported that 397 patients died from a total of 15,687 discharges.

13.3.3. Surgery, Women's, and Oncology Division reported that 168 patients died from a total of 18, 224 discharges.

13.3.4. Clinical Support Services Division reported 0 deaths in the Critical Care Units from a total of 517 discharges.

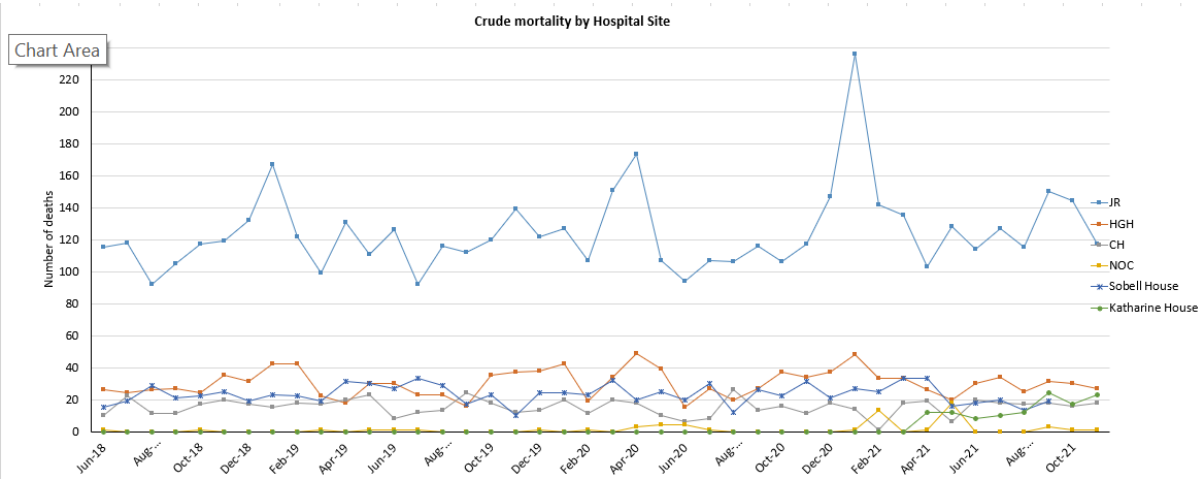
13.3.5. Chart 7 presents the crude mortality by Division.

Chart 7: Crude mortality by Division



13.4. Chart 8 depicts the crude mortality by hospital site. Most deaths occur at the John Radcliffe Hospital which has the highest activity.

Chart 8: Crude mortality by Site



14. Corporate Risk Register and related Mortality risks

14.1 Table 6 draws out the relevant mortality risks from the Corporate Risk Register.

Table 6: Extract from Corporate Risk Register

Risk ID	Summary Risk Description	Proximity	Q1	Q2	Updated target 21/22
C2	Ability to develop internal trust quality improvements and to influence system-wide quality improvement	3-6 months	9	9	6
	Digital by Default				
D2	Potential risk of failing to respond to the results of diagnostic tests	Immediate	9	9	4
D4	Patient harmed because of difficulty finding information across two systems (paper and digital)	Immediate	6	6	3
D5	Failure to provide clinical digital services, including virtual desktop and pharmacy stock control	new		20	8
	Getting the Basics Right				
G9	Unable to deliver the Quality Priorities due to competing demands between on staff time	3-6 months	8	8	4
G11	Aspects of Medicine Management identified as needing improvement	Immediate	9	9	3
G12	Potential harm to patients via never events through staff not following policies (LocSSIPS)	Immediate	4	4	2
ReCo5	Potential harm to patients, staff and the public from nosocomial COVID-19 exposure.	Immediate	6	6	3
ReCo6	Potential for issues with the ability to maintain safe staffing levels during recovery	In 3 months	8	8	8
G30	Clinical prioritisation to the waiting list could lead to patients waiting longer than they would have hoped and could have the potential to cause harm to patients	new	15	15	6

Risk ID	Summary Risk Description	Proximity	Q1	Q2	Updated target 21/22
G31	Lack of capacity to meet the demand for patients waiting 52 weeks or longer	new	12	12	9
G32	Ability to achieve the 85% of patients treated within 62 days of cancer diagnosis across all tumour sites	new	12	12	6
O1	Excessive use of agency staff may pose a risk to the quality of service delivered	In 3 months	6		2
O3	Ability to recruit, retain and engage staff to work together to deliver compassionate excellence and fulfil their potential	Immediate	16	16	8
O10	Having the right staff in the right place at the right time (to include organisational development and the workforce strategy and workforce planning)	new	16	16	TBC

15. Mortality Review Governance

15.1. A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly Mortality Review Group (MRG) Chaired by the Director of Safety and Effectiveness.

15.2. MRG reports are then presented to the Patient Safety & Effectiveness Committee (PSEC) which is Co-Chaired by the Director of Patient Safety and a Divisional Nurse.

15.3. PSEC reports `to Clinical Governance Committee (CGC), Chaired by the Chief Medical Officer or the Chief Nursing Officer.

15.4. CGC reports via Trust Management Executive to the Integrated Assurance Committee (subcommittee of the Trust Board).

16. Recommendations

16.1. The Public Trust Board is asked to receive this paper for information and discuss the learning identified in mortality reviews.